Psychiatry and Primary Care

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General Info

*Substantial changes in health care costs and technological advances have resulted in decreased hospitalization rates and lengths of stays.
*The current goal of medical and psychiatric hospitalization is **stabilization** of the patient.
*Complex treatment regimens and acute conditions are now handled on an **outpatient** basis.
*Primary care practices (PCP) provide the sole contact for more than **50%** of patients with mental illness, and that number is likely to grow.
*PCPs need standardized tx protocols, access to psych consults, and an administrative infrastructure to manage pts with mental health care needs.
*Cost-benefit analysis has indicated that PCP treatment of patients with depression is beneficial. Because the risks are shared among providers of different specialties and the health system, and everyone may be more willing to consider how a pt's psychosocial issues affect health and illness.
*Research is needed to solve problems associated with PCP's dealing with mental health. The problems are: illnesses that are less homogenous than psych settings, comorbid medical illnesses, efficacy, compliance, how to organize treatment resources and detecting psych problems in the PCP setting.
*Psych disorders (d/o) overall in the PCP setting: **60-70%** of pts with anxiety, mood, somatoform, and chemical dependency d/o. Only **20%** are referred to mental health specialists.
*PCP estimate spending **20-50%** of their time with psych problems; they write the majority of Rx for antidepressants and anxiolytic meds.

Depressive and Anxiety D/o

*__10-15%__ of pts in PCP setting have anxiety or depressive d/o

	Pts in PCP
Current Mood d/o	**5-10%**
Generalized Anxiety d/o	**1.6-11.9%**
Panic d/o	**1.6-11%**

*__Comorbid d/o__: **75%** of pts with major depression had lifetime history of an anxiety d/o; **80%** of pts with panic d/o or generalized anxiety d/o also had history of major depression.
*Anxiety d/o was also found in pts with obsessive compulsive d/o (**1.2%**), post traumatic stress d/o (**4.5%**), simple phobia (**10.4%**), and socia phobia (**13%**).
*__5.1-6.6%__ have a mixed anxiety-depression d/o that does not meet criteria for DSM-IV but have a substantial number of related clinical symptoms.

Functional Somatic D/o

*2-3% of women have lifetime risk for somatoform d/o, but it may be as high as 12-26% (different studies and criteria).
*Somatization syndrome proposed with Somatic Symptom Index used as a diagnostic tool. Females need 4 somatic sx's, males need 6 sx's for diagnosis.
*Hypochondriasis ranges from 3-13% in the PCP setting

Substance Abuse d/o

*Alcohol most common (5-15%) with higher numbers in urban areas and low socioeconomic status.
*Others: 5-7%
*Current and lifetime risks increase in pts with major depression and other depressive d/o

Disability and Costs of D/o

*Depression can be more disabling than most chronic illnesses, and the number of reported medically unexplained sx's are increasing. Costs exceed $43billion per year. Appropriate care of depression improves functional capacity but costs more (in all aspects of care). Inadequate care is cheaper, but does not improve functional capacity.

*Anxiety and mixed anxiety-depression cause at least mild impairment, and the impact is $46billion per year.
*Pts with anxiety and depression will have higher health care costs, despite adjustments made for differences in the number and severity of medical conditions

Inadequate Tx of Psychiatric D/o
*patient, provider, and administrative factors (it's not just improving the knowledge and skill of the PCP)

Patient factors	**Provider factors**	**Administrative factors**
Focus on somatic etiology, not sx's	Not adequately prepared (10% of PCP had formal training)	Unable to offer structured psychotherapy
Underestimate the severity	Limited time	Do not facilitate detection of illness
Think it's a normal response to life event	Barriers to prescribing new meds	Discourage proper monitoring of meds
Reluctance to take meds	Lack of reimbursement	Do not offer reimbursement
Limited access to tx	Not my job	
Problems with adherence	Not a legitimate problem	

Studies of the adequacy of treatment
*Failures of recognition and inadequate trials of antidepressant meds.

Study with 2,000 pts	Only 2/3 of pts with depression acknowledged by PCP
	56% of those pts filled their Rx within 3 months
Study with 1,500 depressed pts	35% pts dropped out of tx within 60 days
	35% continued active-phase meds for 6 mo or more
Study with high utilizers of PCP	55% of depressed pts had not had meds the last year
	Only 10% received adequate dose and duration
Recent report with assumptions about depression	5% of pts with depression receive 6mo maintenance meds after acute phase
	Depression is appropriately diagnosed in 50%
	25% of those will get adequate tx (12.5% of total)
	2/3rd respond to the meds (8.5%) of sample
	Less than 2/3rd will continue to take the meds (5% of overall sample)
Medical Outcomes Study	Minor tranquilizers were used more commonly than antidepressants (30%, 23%, respectively)
	39% received subtherapeutic doses
	Sicker pts in PCP were not recognized nor referred and given meds
Outcome of pts with inadequate trials of meds (conflicting findings)	Outcome for inadequately tx pts may not differ from those that are unrecognized, because they are often milder and self-limiting. Severely depressed pts will have a bad outcome
	Severity of illness does not always correlate with use of services
	Pts with unrecognized d/o had substantially more social impairment and disability at follow-up, but used the health care less often

Psychiatric D/o that are **not recognized** in the PCP

All mental d/o	33-79%
Depression	40-50%
Anxiety d/o	41-60%
Somatic d/o	51%

Why are they not recognized?

Patient presentation of illness	PCP underestimate the severity of the depression
	Medical and psychiatric interaction in complex
	PCP encounter more diverse affective and anxiety illnesses
	Ambulatory pts present with more somatic sx's than affective sx's
	Recognition is related to the degree of somatization in pt's presentation

	Comorbid presentations (esp with anxiety d/o and depression)
Guidelines for diagnosing depression	Presence of affective and cognitive sx's is a better determinant of depressive illness in medically ill pts
	Substitutive approach- usual depressive sx's are replaced with another sx of pt
	Inclusive approach- diagnosis based on standardized criteria
	Risk of overdiagnosis of depression: 1.5-8%
Populations at increased risk for mental d/o	Pts that are 'frustrating' to the PCP have a higher incidence of somatization, generalized anxiety, and depressive d/o
	Cancer pts: 18-39%; Parkinson's: 20-50%; pts after stroke: 15-19%; after MI: 5-11%; diabetes mellitus: 5-11%; rheumatoid arthritis: 13%

*How to improve recognition of mental d/o: **notification** (pt fills out screening form that the PCP can read before seeing the pt) and **education** (instruction or psych consult)
*Some studies have failed to find associations with recognition of mental d/o and a better outcome. It is thought that the PCP must have the skills and the resources to perform adequate interventions as well.
***Notification** (mentioned above) led to increase in chart documentation of mental d/o, referrals, and outpatient visits but **NOT** an increase in the use of psychotropic meds or the rate of hospitalization.

Psych Consultation in the Primary Care Setting
*Three Models: variable is the amount of direct contact that the consultant has with the patient
*Problems with consultation: record-keeping and lack of office space
*100% of PCP preferred on-site treatment of depression to referral of depressed pts to a specialty clinic

Traditional Referral or Replacement Model	Psychiatrist is the principal provider of mental health services; limited communication with PCP
Consultation Care Model	PCP is the principal provider of mental health services; close communication with the psychiatrist
	Young psychiatrists more likely to be consultants
	Like a "for profit" system; study showed impressive short-term savings, but less effective and higher long-term costs because of poor pt outcome
Collaborative Care Model or Liaison-Attachment Model	Mental health services are provided jointly; joint sessions and frequent communication
	Most PCPs prefer this
	1995 study: measurable effect on clinical outcome of major depression and more modest effect on tx of minor depression

Administrative Considerations for Psych Consultations include location, the consultee, trainees, continuity, organizational elements, and of course $$$$.
*Location as close as possible to the PCP center is the most effective. This allows "curbside consultation," convenience to the pt, better communication, and a greater sense of confidentiality for the pt.
*Telemedicine is being utilized. In 1995, 50 Interactive television (IATV) programs were in use and 6,267 doctor-pt consultations took place with the duration averaging 33.4 minutes. Considerations of the use of telemedicine include: pt satisfaction, reliability and validity, legal ramifications, and economic issues.
*The consultee's PCP specialty affects the choice of consultation model: FP and General Practitioners prefer collaborative or consultation care models. Internists and Peds prefer traditional referral models.
*Trainees have positive effect- they invigorate the Drs and staff with their interest in the psych issues of pt care, but training also takes time.
*Rapid turnover of consulting psychiatrists disrupts the process of collaborative care of pts.
*Administrative problems (mechanism of referral, charting, communicating, arranging follow-ups, etc) are frequently sited by PCP as the primary obstacle to effective psych consultation.
*Show me the money: without reimbursement, it does not matter how well-oiled your machine is.

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Detection of Psychiatric Disorders in the Primary Care Setting

Self-Report Questionnaires- screen many psychiatric disorders.
Examples:
-General Health Questionnaire: for depression, anxiety, social impairment, hypochodriasis
-Mental Health Inventory: Multiple symptoms, and disorders
-Hopkins Symptom Checklist: multiple symptoms and disorders, including somatization

Depression: Questionnaires used are the Beck Depression Inventory (BDI), the Center for Epidemiological Scale Depression Test, and the Zung Self-Rating Depression Scale.
The BDI is the best-studied questionnaire for depression. It measures cognitive, affective, motivational and physiological types, takes less than 10 minutes to complete and is well received by ambulatory patients.

Anxiety: Two questionnaires used: The Zung Self-Rating Anxiety Scale, and the Beck Anxiety Inventory.

Substance Use Disorders: Most physicians prefer informal clinical setting to questionnaires, and up to 90% of cases of substance abuse go undetected. This is because many physicians ask a single question regarding a patient's use of alcohol. CAGE questionnaire should be used more often. It has sensitivity of 0.94 and specificity of 0.97 for problems in the past year, and sensitivity of 0.91 and specificity of 0.84 for detection of problems over a lifetime.

Two other questionnaires are used: The Michigan Alcoholism Screening Test (MAST) and The Alcohol Use Disorders Identification Test (AUDIT)

Rating Scales and Structural Clinical Interviews

-DSM-IV Primary Care Version: for common mental disorders in primary care
-Primary Care Evaluation of Mental Disorders (PRIME-MD): for mood, anxiety, alcohol use, somatoform, and eating disorders.
-Symptom Driven Diagnostic System for Primary Care (SDDS-PC): for depression, panic, alcohol use, obsessive-compulsive, anxiety disorders, and suicidal ideation.
-Hamilton Anxiety Scale: for anxiety and somatic symptoms.

To determine Depressive and Anxiety Disorders use:

1. Hamilton Ration Scale for Depression (commonly used)
2. Hamilton Anxiety Scale (currently determining usefulness in a primary care setting)
3. DSM-IV field trial uses DSM-III-R criteria
4. DSM-IV (ADIS-IV) used by psychiatrists

To detect Functional Somatic Disorders use:

1. Hamilton Anxiety Scale (extensively used)
2. Illness Attitude Scale (distinguishes hypochondriac behaviors from other psych patients)
3. Brief Rating Scale of Hypochondriasis (high interrater reliability)
4. The Hypochondriasis subscale of the Minnesota Multiphasic Personality Inventory (somatic symptoms only)
5. Structured interview based on DSM-III-R

To identify Substance Use Disorders use:

1. Structured Clinical Interview for DSM-III-R
2. The addiction Severity Index (gets info about the pt's life that contributes to substance abuse)

The recovery Attitude and Treatment Evaluator (assesses pt's obstacles to treatment)

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PATIENT AND FAMILY ISSUES

- Potential difficulties w/ regard to compliance should be identified, along w/ strategies for management
- specific counseling on compliance may be indicated for pts. w/ histories of poor compliance, substance use or personality d/o, unfounded negative attitudes toward selected tx, or marked lack of understanding about illness
- >7 studies found that pt. education helps ensure tx. compliance in depressed outpatients

PRINCIPLES FOR Tx OF DEPRESSION

- effective management depends on accurate diagnosis and adequate tx. w/ meds.
- must ruled out depressive syndromes due to medical illnesses or medication use, and must be treated rapidly if present
- Three distant phases of Tx.

Acute Phase

- Includes Tx. w/ medications and/or psychotherapy
- Initial Tx. for pts. w/ more severe and chronic depression, psychotic, melancholic, or recurrent depression and those w/ a strong family history of depression should be antidepressant Tx.
- Serotonin reuptake inhibitors assoc. w/ less risk of fatal overdose, have more tolerable side effects, and require less dosage adjustments
- Pts. should be seen every 2 wks for reevaluation of symptoms, checking for side effects and adjustment of dosage
- Assessment of outcome should occur at 6 wks.; if partial response present then Tx. should be continued for total of 12 wks.
- Lack of response at 6 wks. or partial response at 12 wks then another agent should given considered
- Partial response at max. dosage then another agent should be considered
- Psychotherapy recommended for pts. w/ less severe, less chronic, nonpsychotic, and nonmelancholic depression
- Interpersonal, cognitive, behavioral, brief dynamic, and marital psycho therapies shown to benefit pts.
- Approx. 50% psychiatric outpts. improved over 12 wks. when undergoing these therapies

Continuation Phase

- Tx. of depression w/ medication should be continued in this phase b/c high rate of relapse
- Recommended pts. have 6-9 month course of antidepressant Tx. once in remission
- Decision to implement continuation-phase psychotherapy depends on pt.'s residual Sx, psychosical problems, and history of psychological funct. b/w episodes and pt. and physician's judgment

Maintenance Phase

- Maintenance-phase Tx. of depression usually continues for >1 yr.
- Rate of relapse is 4x for pts. taking placebo
- Psychotherapy indicated for women who wish to become pregnant and bear a child in drug-free condition

Studies of Patient Care w/ Regard to AHCPR Guidelines

- Only 30%-40% primary care pts. w/ major depression undergo antidepressant Tx. according to AHCPR guidelines

PRINCIPLES FOR Tx OF ANXIETY

- no formal clinical practice guidelines have been developed for Tx. of anxiety d/o in primary care setting
- effective Tx. rests on accurate dx.
- must rule out anxiety syndromes due to medical illnesses or medications and treated rapidly
- anxiety d/o have been divided into acute and persistent anxiety b/c **primary care physicians rarely use DSM-IV!** (SO WHY DID I BOTHER LEARNING IT?)
- pts. w/ minor illnesses improve regardless of Tx. and severely ill pts. need intensive services available only in mental health settings

PRINCIPLES FOR Tx OF FUNCTIONAL SOMATIC SYMPTOMS

- presence of medically unexplained sx. is a frequent reason for psychiatric consultation in primary care settings
- management of functional somatic symptoms in primary care settings is similar to that in outpatient psychiatric setting, exception being that psychiatrist collaborate w/ primary care physicians
- overall approach to these pts. involves development of a good physician-pt. relationship, performance of a physical examination at each visit, techniques of behavior modification, engagement of pt. at somatic level but including life stresses among issues to be addressed, Tx. of comorbid condt., and regularly scheduled brief visits irrespective of Sx.
- 2 studies showed psychiatric consultation and instructive letter to physician about diagnostic and therapeutic measure resulted in sharp reduction in health care charges w/ no change in pt. satisfaction
- key to Tx. of hypochondriasis, like somatization d/o, is recognition of illness

PRINCIPLES FOR Tx OF SUBSTANCE USE DISORDERS

- substance use d/o are usually not Tx. in primary care setting
- after primary care physician dx. of d/o pt. encouraged to obtain Tx.
- pt. referred to community self-help programs to a psychiatrist or another mental health professional for ongoing individual or group psychotherapy, and/or to a residential Tx. program

CONCLUSION

- Primary care setting is a site of vital importance in provision of medical and mental health care
- collaboration b/w psychiatrist and primary care physicians is vital to determining most efficient methods of organizing care
- consultation-liaison psychiatrist are uniquely qualified for playing a key role in improving pt. care by facilitating integration of care and fostering collaboration

gap must be narrowed b/w knowledge and Tx. of mental d/o in primary care setting